ANNUAL REPORT

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

ARIZONA'S

Under Title XXI of the Social Security Act

Table of Contents

PREAMBLE **1**

SECTION 1: DESCRIPTION OF PROGRAM CHANGES AND PROGRESS **2**

SECTION 2: AREAS OF SPECIAL INTEREST **21**

SECTION 3: SUCCESSES AND BARRIERS **29**

SECTION 4: PROGRAM FINANCING **32**

SECTION 5: SCHIP PROGRAM AT-A-GLANCE **34**

SECTION 6: INCOME ELIGIBILITY **38**

SECTION 7: FUTURE PROGRAM CHANGES **41**

ATTACHMENT A, A-1 and A-2: OUTREACH MAPS
- Counties Targeted for Kids Outreach by AHCCCS Employees
- Counties Targeted for KidsCare Outreach by Foundations
- IHS Facilities and Other Entities that Target the KidsCare Population

ATTACHMENT B: APPLICATIONS
- Total Kids Approved for Health Care Coverage Due to KidsCare Graphic
- Number of Applications Graphic

ATTACHMENT C: KIDSCARE IMPACT
- KidsCare and Transfers To Title XIX Graphic

ATTACHMENT D: OUTREACH LIST
- List of Outreach Customers/Partners

ATTACHMENT E: KIDSCARE CONSUMER INFORMATION
- Flyer

ATTACHMENT F: STATE BY STATE SCHIP ENROLLMENT COMPARISON
- Kaiser Commission: Enrollment in State CHIP Programs: December 1998 to June 1999 (Chart)

ATTACHMENT G: CONTRIBUTING FACTORS TO MEDICAID GROWTH
- Additional information on increase in the Medicaid Population

ATTACHMENT H: DEMOGRAPHICS
- Age
- Ethnicity

PREAMBLE

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs;
- Provide *consistency* across States in the structure, content, and format of the report;
- Build on data *already collected* by HCFA quarterly enrollment and expenditure reports; and
- Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

SUBSECTION 1.1

PLEASE EXPLAIN CHANGES YOUR STATE HAS MADE IN YOUR SCHIP PROGRAM SINCE SEPTEMBER 30, 1999 IN THE FOLLOWING AREAS AND EXPLAIN THE REASON(S) THE CHANGES WERE IMPLEMENTED.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program Eligibility
   NC

2. Enrollment Process
   The cap on Phoenix Health Plan was lifted effective September 1, 2000. There are no other changes.

3. Presumptive Eligibility
   NC

4. Continuous Eligibility
   NC

5. Outreach/Marketing Campaigns
   The AHCCCS Administration, foundations and community organizations, health plans as well as Indian Health Services (IHS) and Tribal agencies continue to expend diversified energy in their efforts to capture the varied cultural populations, which encompass KidsCare. (See Attachments A, A-1 and A-2 for a visual review by county and organization of outreach efforts.) (See also page 22 section 2.5 #2 for more detail.)

   The AHCCCS KidsCare Administration, in partnership with the entities noted above, have impacted the number of enrollments in the SCHIP and Medicaid programs because of the emphasis placed on outreach strategies. (See Attachment B regarding KidsCare application figures and Attachment C regarding Medicaid figures as a result of KidsCare.) The major outreach methods, innovations and successes are noted as follows.

   AHCCCS Strategies & Activities
   AHCCCS has been increasing and strengthening its efforts since October, 1999. The social marketing outreach strategies conducted by AHCCCS include but are not limited to the following:
   - One-on-One Interventions (e.g., counseling and referral and event-based outreach);

- A referral hotline and information number (1-877-764-KIDS (5437);
- Mobilization of community coalitions:
  - Associations (Neighborhood Association and PTA meetings),
  - Counties,
  - Community health centers,
  - Chamber of Commerce, and
  - Children's organization;
- Partnerships with School Districts, individual schools and school based clinics;
- Information sharing with foundations (The Flinn Foundation and St. Luke's Charitable Trust);
- Partnerships with sister state agencies (Department of Health Services, Department of Economic Security, and Department of Education);
- Partnerships with Community organizations (Big Brother Big Sister Program, fire departments, events in malls);
- Inter relationships with health organizations (hospitals, doctors, clinics, immunization clinics and events, and Arizona Rural Health Team);
- Inter relationships with Tribal entities;
- Usage of Mass media (TV and radio) and small media (brochures, flyers and posters); and
- Small or large group interventions (e.g., events like health fairs, presentations, peer workshops, and lectures).

The following bullets describe various AHCCCS activities associated with some of the strategies previously noted.

Varied Marketing Techniques

The KidsCare Administration has hired four Regional Outreach Coordinators to direct statewide outreach activities (Attachment A for map of geographic catchment areas and See Attachment D for an example of outreach partners). Together these coordinators have developed an outreach plan which includes:

- Supporting and collaborating with the community based organizations on outreach events and in setting up community coalitions *(mobilization & small and large group intervention),*
- Training and education *(small and large group intervention),*
- Creating uniform outreach training materials *(small media*), and
- Developing a business packet to target the small business and minority business companies *(small media).*

Mobilization of Community Coalitions

AHCCCS and the community are intensifying their outreach efforts as evidenced by:

- The City of Phoenix Parks, Recreation and Library Administration recently agreed to pursue the following strategies:
  - Distribute KidsCare information to all of their part-time staff in four park districts because many are young people age 18 and under;
  - Distribute information at their after school programs that are located at 150 different

schools, (Each after school program site serves anywhere from 30 to 180 children);
- Allow KidsCare staff to speak at their next supervisor's meeting (200 people) which is scheduled for January;
- Review the intake form they currently utilize to collect information from the parents of the children that attend the recreation programs. Additional questions concerning access to health care will be included on the application;
- Have AHCCCS train their staff regarding the completion of KidsCare applications so that they can be taken onsite; and
- Insert information in the department's newsletter and in employee's paychecks.

- The City of Phoenix Manager's Youth and Education Office agreed to insert information concerning KidsCare in their newsletter that is distributed to all school principals in the City of Phoenix and Maricopa County.

Sister State Agency

- AHCCCS and the Department of Education (DOE) recently partnered to notify families of the KidsCare program through the Child Nutrition Program. Each school program received a letter and flyer from DOE requesting that the flyer be attached to the application for the free and reduced lunch program. Families completed the simple form and returned it to the school if their child was uninsured, and they wanted more information about KidsCare. The schools have been submitting the flyer to the KidsCare office for follow-up. AHCCCSA staff call these families to not only answer questions, but also to assist in the completion of the application over the telephone. To date we have received over 7,000 letters from more than 25 school districts.

Health Organization

- AHCCCS, in conjunction with the Health Care Financing Administration, sponsored a two-day Social Marketing Workshop for staff and representatives from the minority communities, foundations, department of health services, tribal entities, and community based organizations that are currently performing outreach for the KidsCare program. The workshop was presented by the Academy for Educational Development. Approximately 35 people attended the workshop.

Tribal Entities

- AHCCCS is also working diligently to increase the enrollment of Native American families in both reservation and urban communities. The *KidsCare News* is a newsletter that provides KidsCare information that is of specific interest to tribal communities. The informative publication includes KidsCare updates, AHCCCS outreach efforts and events, tribal enrollment statistics as well as the KidsCare eligibility requirements and income limits. The AHCCCS Native American Coordinator provides opportunities for both communication and education and is a key link between AHCCCS and the twenty-one Tribes.

Mass Media/Small Media

- AHCCCS maintained its contract with the media firm, Riester/Robb through June 30, 2000. They have been particularly helpful in outreach efforts to the minority community.

- A newly developed flyer will be enclosed with the renewal form (See Attachment E). The flyer contains the name and address of community based organizations and other agencies that have agreed to provide assistance in completing the renewal form, faxing the form to the KidsCare office and making copies of income verification such as paycheck stubs if families have verification available. If not, self-declaration of income will be accepted unless it seems incorrect or inconsistent based on other information known about the family. They will also assist in completing the KidsCare application form. These entities are listed by county to assist the applicant in locating the office closest to their home.

Community Organizations: Strategies & Activities

Through a grant from the Flinn Foundation, Arizona State University (ASU) is currently compiling the outreach program data for Children's Action Alliance, Flinn Foundation and St. Luke's Charitable Trust. The summary report is expected at the end of the three-year projects. While it is too early for outcomes, these grants are allowing communities the opportunity to provide outreach that was previously unavailable.

- Children's Action Alliance (CAA)
  CAA dispersed $1 million in grants from the Robert Wood Johnson Foundation to El Rio Community Health Center in Tucson, Phoenix Day School Health Links Project, and Yuma Department of Public Health. The purpose of these grants is to:
  - Decrease the number of uninsured
  - Increase access to care
  - Provide technical assistance in outreach
  - Produce publications
  - Increase collaboration

- Flinn Foundation
  In addition to the evaluation grant to ASU, the foundation has awarded KidsCare outreach grants totaling $130,825 to Children's Action Alliance in Phoenix, Interfaith Cooperative Ministries in Phoenix, North Country Community Health Center, Inc. in Flagstaff, Phoenix Day Child and Family Learning Center, Pinal County Division of Public Health in Coolidge, and Yavapai Big Brothers Big Sisters in Prescott. These organizations provide:
  - Information through employer-based activities,
  - Assistance in the application process,
  - Follow up to assure that all eligibility and enrollment processes are completed, and
  - Compilation and analysis of data for community projects (ASU).

- St. Luke's Health Trust Initiatives

The Kids Connect initiative is a three-year program that began in the spring of 1999. The initiative granted a total of $840,213 to Maricopa County East Valley Boys & Girls Clubs, Lake Powell Medical Center which also covers Page and Chapter Houses on the Navajo Reservation, Patagonia School Districts in Patagonia, Santa Cruz County, Phoenix Children's Hospital and Native American Community Health Center, Pima Prevention in Tucson, Scottsdale Prevention Institute, and Valley Interfaith Project for central and western Phoenix.

The goal is to increase the number of children enrolled in Medicaid and KidsCare in order to foster a consistent source of health care. This initiative works through seven community-based organizations to:

- Identify children not receiving health care who are eligible but not enrolled in AHCCCS or KidsCare,
- Assist parents with the application process, and
- Ensure that the child receives health care.

This program is intended to complement AHCCCS and KidsCare by testing innovative strategies to reach these populations. Strategies have included outreach activities at:

- Youth rodeos,
- Wal-Mart,
- Churches,
- Health fairs, and
- Schools.

Health Plans Strategies & Activities

AHCCCS contracted health plans are also contributing to the KidsCare outreach efforts. Health Plans statewide have promoted the KidsCare Program at health fairs and community events such as block watch gatherings and cultural events.

IHS & Tribal Entities Strategies & Activities

IHS facilities and Tribal entities statewide, have been and continue to be very diligent in screening and assisting families with the completion of KidsCare applications. They are part of the success in the substantive increase in Native American KidsCare enrollment. Examples of these varied outreach efforts are as follows:

- The number of Native American children in the KidsCare program has continued to increase at a modest but steady level, at a rate of approximately 100 children per month during calendar year 2000. The majority of these children were enrolled through the efforts of the IHS facilities. Each IHS facility is mandated to explore alternative health care resources for Native Americans. Throughout the state, the IHS facilities have contributed to the expanding enrollment for children who reside on reservations. Accordingly, most eligible families have opted to enroll their children with IHS as their health plan;

- Tribally operated health care programs have also contributed to the enrollment of Native American children. Each tribe designed their outreach plans based on the uniqueness of their communities:
  - Organizing community health fairs and other events focusing primarily on children's health.
  - Incorporating the application process into other tribal programs by capturing information that can also be used to complete the KidsCare application;

- Such programs as Women, Infants and Children, Head Start, and other social service and educational programs have also played an active role in assisting families enroll their children in KidsCare;

- There are other programs in the state's metropolitan areas that target the Native American community. Through a grant from St. Luke's Charitable Trust, the Native American Community Health Center and the Phoenix Children's Hospital have hired outreach and enrollment specialists to assist families in completing application forms. These programs have hired staffs of Native American heritage who are able to interact with Native American families residing in urban areas. The staff also follow up with families by:
  - Conducting home visits,
  - Assisting potential applicants with verification of income documents, and
  - Generally providing consumer education to make an informed choice regarding health plan selections.

6. Eligibility Determination Process

On October 2000, the KidsCare Administration implemented a policy change that allows applicants to declare income. An Eligibility Interviewer (EI) compares the declared income with the income screens available. If a major discrepancy exists, the EI will issue a pending notice requesting information and/or contact the applicant's employer to verify income. This process was not implemented earlier because AHCCCS was evaluating the accuracy of its dispositions, changing policy and developing/conducting training prior to rolling out this change.

7. Eligibility Redetermination Process

KidsCare initially sent out a pre-printed form for renewal. Due to a low rate of return, KidsCare has streamlined the renewal process by developing a one-page renewal application form written in Spanish and English. Additionally, the form was designed to be more comparable to a medical insurance form. This was done to position the KidsCare program as more of a medical insurance program rather than a welfare program. Results of this methodology will be submitted in the FFY 2001 report.

8. Benefit Structure

NC

9. Cost-Sharing Policies
AHCCCS added text to the application to clarify that Native Americans are not charged premiums.

10. Crowd-Out Policies
NC

11. Delivery System
NC

12. Coordination with Other Programs (especially private insurance and Medicaid)
NC

13. Screen and enroll process
NC

14. Application
Phoenix Health Plan was added as a health plan choice. As noted previously, the application now clarifies that Native Americans are not charged a premium.

15. Other
None

SUBSECTION 1.2

PLEASE REPORT HOW MUCH PROGRESS HAS BEEN MADE DURING FFY 2000 IN REDUCING THE NUMBER OF UNCOVERED, LOW-INCOME CHILDREN.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.
As of October 1, 2000, 38,073 children were enrolled in the KidsCare program. This information is from monthly enrollment reports generated from the KidsCare Enrollment Determination System (KEDS).

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.
As of October 1, 2000, 44,906 children were enrolled in Medicaid as a result of the KidsCare application process. This information is from the monthly enrollment reports generated from the KEDS.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-

income children in your State.

The Kaiser Commission on Medicaid and the Uninsured in the November, 2000 edition of "Enrollment Increases in State CHIP Programs: December 1998 to December 1999 indicates that Arizona is ranked fifth in the increase of growth for that timeframe with a percentage of growth of 648% (See Attachment F). AHCCCS believes that this growth is indicative of the growth pattern for the current timeframe in review.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

X No, skip to 1.3

____ Yes, what is the new baseline?--

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

SUBSECTION 1.3

COMPLETE TABLE 1.3 TO SHOW WHAT PROGRESS HAS BEEN MADE DURING FFY 2000 TOWARD ACHIEVING YOUR STATE'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS (AS SPECIFIED IN YOUR STATE PLAN).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Decrease the percentage of children in Arizona who are uninsured or do not have a regular source of health care.	Decrease the percentage of children in Arizona who are uninsured. In the first year of the KidsCare program, decrease the percentage of children with income under 150% of FPL who are uninsured. In subsequent years, decrease the number of children with income under 200% of FPL who are uninsured.	**Data Sources:** Current Population Survey (CPS) AHCCCS monthly enrollment figures **Methodology:** During this reporting period, AHCCCS used CPS data for the number and percent of children under 19 years of age, at or below 200 percent of FPL, based on three-year averages for 1996, 1997, and 1998. AHCCCS also used monthly enrollment figures to determine the number of children who currently have creditable coverage. **Numerator:** Total KidsCare and Medicaid enrollment **Denominator:** Baseline figure of 311,000. **Progress Summary:** As of October 1, 2000, AHCCCS had insured 82,979* children (Title XIX and Title XXI) in Arizona. (See also outreach efforts pages 2-7, Section 1.1, #5 which describes the positive impact of outreach on enrollment; and information contained in table 1.3 "SCHIP and Medicaid Enrollment".) **Note:** *This is a current monthly figure. It does not represent the total number of children approved. Each month children leave the program for various reasons.

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Decrease the percentage of children in Arizona who are uninsured or do not have a regular source of health care.	Decrease the percentage of children in Arizona who are uninsured. In the first year of the KidsCare program, decrease the percentage of children with income under 150% of FPL who are uninsured. In subsequent years, decrease the number of children with income under 200% of FPL who are uninsured.	**Data Sources:** Current Population Survey AHCCCS monthly enrollment figures **Methodology:** During this reporting period, AHCCCS used CPS data for the number and percent of children under 19 years of age, at or below 200 percent of FPL, based on three-year averages for 1996, 1997, and 1998. AHCCCS also used monthly enrollment figures to determine the number of children who currently have creditable coverage. **Progress Summary:** As of October 1, 2000, 38,073 children were enrolled in the KidsCare Program. (See also outreach efforts pages 2-7, Section 1.1, #5 which describes the positive impact of outreach on enrollment; and information contained in table 1.3 "SCHIP and Medicaid Enrollment".) **Note:** *This is a current monthly figure. It does not represent the total number of children approved. Each month children leave the program for various reasons.

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
OBJECTIVES RELATED TO MEDICAID ENROLLMENT		

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
Coordinate with other health care programs providing services to children to ensure a seamless system of coverage.	Coordinate with other health care programs providing services to children to ensure a seamless system of coverage. Out Station KidsCare Eligibility Workers in Yuma, Flagstaff, and Pima counties to assist with outreach activities and applications and maximize coordination with other health care programs. Eligibility workers are outstationed to assist with outreach efforts. **Note: During FFY 2000 AHCCCS established four Outreach Coordinators to improve and enhance outreach strategies. The coordinators have geographic areas which cover the entire state (Attachment A).**	**Data Sources:** Internal KidsCare eligibility data and Medicaid enrollment data. **Methodology:** Record match between SCHIP eligibility data and Medicaid enrollment data performed. **Numerator:** Number of children enrolled in Medicaid because of KidsCare application. **Denominator:** Total number of children who have creditable coverage because of KidsCare application. **Progress Summary:** As of October 1, 2000, approximately 44, 906 children were transferred from KidsCare to Title XIX or KidsCare was denied and Title XIX was approved. This is an increase of 16,817 (79%) children. Since 10/1/99, an average of 2,061 children who have been approved for KidsCare were transferred to Title XIX. (See Attachment A-1, A-2, B, C and G for further detail.) (See also outreach efforts pages 2-7, Section 1.1, #5 which describes the positive impact of outreach on enrollment.) **Note:** *This is a current monthly figure. It does not represent the total number of children approved. Each month children leave the program for various reasons. KidsCare and Title XIX have coordinated efforts to ensure a smooth eligibility determination process: • DES staff have been trained to process dual applications. • AHCCCS and DES meet weekly regarding KidsCare and Medicaid activity. • Manuals have been written for the dual eligibility process.

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
Ensure that KidsCare eligible children in Arizona have access to a regular source of care and ensure utilization of health care by enrolled children.	Ensure that KidsCare enrolled children receive access to a regular source of care: 1. 100 percent of enrolled children will be assigned a PCP. 2. 70 percent of KidsCare children will see a PCP at least once during the first 12 months of enrollment.	**Data Sources:** HEDIS (Health Employer Data Information Set) criteria used as a guide. **Methodology:** The increase in the percentage of children with a usual source of care/ **Numerator:** 1. Number of children assigned a PCP, and 2. Number of children who see a PCP at least once During the first 12 months of enrollment. **Denominator:** The total number of children enrolled in KidsCare. **Progress Summary:** 1. Once members have picked a health plan, if they do not opt to pick a primary care physician (PCP), they are assigned a PCP. 2. While the overall objective of 70 percent was not met, the rate of access to care among one- and two-year-olds is only slightly under the objective. Two year olds have the highest rate of visits, with 68.6 per cent. For one year olds, the rate is 64.4 per cent. This may be due to the fact that Arizona has several active and effective outreach programs specifically aimed at ensuring that infants and toddlers receive critical preventive services, including well-child visits. The overall baseline for FFY 98-99 was determined to be 60 per cent. AHCCCS will be submitting FFY 2000 Title XXI and Title XIX encounter data together, per HCFA guidelines as agreed to in the KidsCare State Plan Amendment #99-03.

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

Table 1.3		
(1) **Strategic Objectives** **(as specified in Title XXI State Plan and listed in your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress** **(Specify data sources, methodology, time period, etc.)**
Improve the health status of children in KidsCare through a focus on early preventive and primary care.	Improve the number of KidsCare eligible children who receive preventive and primary care by meetings the goals below: 80 percent of children under two will receive age appropriate immunizations; 60 percent of children under 15 months will receive the recommended number of well child visits; 60 percent of three, four, five, and six year olds will have at least one well child visit during the year; 50 percent of children will have at least one dental visit during the year.	**Data Sources:** HEDIS (Health Employer Data Information Set) criteria used as a guide. **Methodology:** AHCCCS will report KidsCare data in conjunction with the required Medicaid reports. The areas are immunizations, well childcare, satisfaction with care and dental care. **Numerator:** Number of children receiving immunizations, well childcare, satisfaction with care and dental care. **Denominator:** Number of children enrolled. **Progress Summary:** AHCCCS and the contracted health plans are working to achieve the state public health goal to increase the proportion of children who are fully immunized by age two to 90% (state goal is higher than Hedis). KidsCare provides a mechanism under which immunizations and other services are covered for more children. The immunization audit results will be available after February 1, 2001. The AHCCCS oral health care goal is to increase to at least 50% percent the proportion of children who have received appropriate oral health care services. Children in the KidsCare program are included in the strategies that were developed by the AHCCCS Dental Care Task Force with regard to increasing oral health visits and practitioners. The KidsCare children were included in the 17,636 (43%) children in all AHCCCS programs who received both preventive and treatment services. AHCCCS will be submitting FFY 2000 Title XXI and Title XIX encounter data together, per HCFA guidelines as agreed to in the KidsCare State Plan Amendment #99-03.

OTHER OBJECTIVES		
Avoid "crowd-out" of employer coverage.	Screen 100 percent of applications to determine if the child was covered by an employer sponsored insurance within the last six months.	**Data Sources:** Enrollment application **Methodology:** 1. Application will screen family on previous coverage. 2. The Administration will monitor percent of total denials due to applicant having group or other health insurance and the delay in enrolling a child pending expiration of a six-month bare period. **Numerator:** Number of applications screened for crowd-out and number actually denied for this reason. **Denominator:** Number of applications. Progress Summary: AHCCCS does not enroll an applicant who has had other insurance six months prior to enrollment in KidsCare. As of September 30, 2000, 1552 children or 4.2 percent of the total denials have been because the applicant was covered by group or other insurance. This figure does not include those children who were denied because they already had Title XIX coverage.

SUBSECTION 1.4

IF ANY PERFORMANCE GOALS HAVE NOT BEEN MET, INDICATE THE BARRIERS OR CONSTRAINTS TO MEETING THEM.

This is the first year AHCCCS has measured access to primary care services by children enrolled in KidsCare. Results reflect a baseline for participation in the program. Data was collected by age group (1 year, 2 years, 3 through 6 years, 7 through 11 years, and 12 through 18 years) for children who were covered by KidsCare and continuously enrolled in a health plan from 31 days of age (allowing for no more than one break in enrollment, not to exceed 31 days), and who had at least one visit with an AHCCCS primary care provider.

While the overall objective of 70 percent of KidsCare enrollees having a PCP visit during the year was not met, the rate of access to care among one- and two-year-olds was only slightly under the objective. Two-year-olds had the highest rate of visits, with 68.63 percent seeing a PCP during the year; for one-year-olds, the rate was 64.4 percent. This likely is due to the fact that Arizona has several active and effective outreach program aimed at ensuring that infants and toddlers receive critical preventive services, including immunizations and well-child visits.

Utilization of PCP services among KidsCare members is lower than that of children covered under Title XIX. This may be due to the fact that KidsCare coverage is likely to be viewed more as conventional insurance – that is, a means of paying for medical care when children are ill or need emergency services, rather than a preventive health care program. Families in this eligibility category have higher incomes than other AHCCCS members, but still are among the "working poor." Thus, they may face some of the same difficulties as other AHCCCS members in utilizing routine services (ability to take time off work, transportation, etc.) AHCCCS will continue to monitor this issue.

SUBSECTION 1.5

DISCUSS YOUR STATE'S PROGRESS IN ADDRESSING ANY SPECIFIC ISSUES THAT YOUR STATE AGREED TO ASSESS IN YOUR STATE PLAN THAT ARE NOT INCLUDED AS STRATEGIC OBJECTIVES.

The State Plan identified four performance goals related to utilization of specific services by KidsCare members. For the Immunization Audit for FY 1999/2000, AHCCCS will measure and report separately the percent of two-year-old children enrolled in KidsCare who are adequately immunized.

SUBSECTION 1.6

DISCUSS FUTURE PERFORMANCE MEASUREMENT ACTIVITIES, INCLUDING A PROJECTION OF WHEN ADDITIONAL DATA ARE LIKELY TO BE AVAILABLE.

The immunization rates for KidsCare members discussed in 1.5 will be available February 1, 2001. In addition, the HCFA 416 Report, which tracks services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, will report KidsCare members with the Medicaid Members. This report is due to HCFA April 1, 2001.

SUBSECTION 1.7

PLEASE ATTACH ANY STUDIES, ANALYSES OR OTHER DOCUMENTS ADDRESSING OUTREACH, ENROLLMENT, ACCESS, QUALITY, UTILIZATION, COSTS, SATISFACTION, OR OTHER ASPECTS OF YOUR SCHIP PROGRAM'S PERFORMANCE. PLEASE LIST ATTACHMENTS HERE.

ATTACHMENT A, A-1 and A-2: OUTREACH MAPS
- Counties Targeted for Kids Outreach by AHCCCS Employees
- Counties Targeted for KidsCare Outreach by Foundations
- IHS Facilities and Other Entities that Target the KidsCare Population

ATTACHMENT B: APPLICATIONS
- Total Kids Approved for Health Care Coverage Due to KidsCare
- Number of Applications

ATTACHMENT C: KIDSCARE IMPACT
- KidsCare and Transfers To Title XIX

ATTACHMENT D: OUTREACH LIST
- List of Outreach Customers/Partners

ATTACHMENT E: KIDSCARE CONSUMER INFORMATION
- Flyer

ATTACHMENT F: STATE BY STATE SCHIP ENROLLMENT COPMARISON
- Kaiser Commission: Enrollment in State CHIP Programs: December 1998 to June 1999 (Chart)

ATTACHMENT G: CONTRIBUTING FACTORS TO MEDICAID GROWTH
- Additional information on increase in the Medicaid Population

ATTACHMENT H: DEMOGRAPHICS
- Ethnicity
- Age

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

SUBSECTION 2.1

FAMILY COVERAGE

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.
   Not Applicable

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?
   Number of adults 0
   Number of children 0

3. How do you monitor cost-effectiveness of family coverage?
   Not Applicable

SUBSECTION 2.2

EMPLOYER-SPONSORED INSURANCE BUY-IN

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
   Not Applicable

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?
   Number of adults 0
   Number of children 0

SUBSECTION 2.3

CROWD-OUT

1. How do you define crowd-out in your SCHIP program?
   The crowd-out provision for KidsCare states that a child cannot have creditable health insurance

coverage for a period of six months prior to enrollment in the KidsCare Program. On the application form, KidsCare staff screen for other health insurance.

2. How do you monitor and measure whether crowd-out is occurring?
This information is provided via a monthly denial report indicating reason for denial. If a child has three months or less before their period of ineligibility ends, AHCCCS pends the case for review and reprocess after the period of ineligibility.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.
These monthly reports show that approximately 4 percent of applicants are denied KidsCare due to having other health insurance within the past six months.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.
See responses for #2 and #3 above.

SUBSECTION 2.4

OUTREACH

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

   Immunization events, working with community organizations to promote KidsCare and participation in various outreach events such as area swap meets have all been effective in reaching this population. For example, 19 events that took place from February through August, 2000, resulted in a total of 380 applications being taken and 866 potentially eligible children. Approximately 50% appeared to be eligible for KidsCare and 50% for Medicaid.

   One activity that AHCCCS has found to be effective is the swap meet. The swap meets were advertised in advance on Spanish radio stations. A disc jockey was present and broadcasting from the site, letting people know what information and verification to bring to the booth. Three of these events resulted in 415 applications which consisted of 704 children. Sixty percent of the people provided verification at the event resulting in complete, ready-to-work applications

   See also "Outreach" Section 1.1 #5, pages 2-7 for a description of numerous other successes and innovative partnerships.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

   The following are examples of strategies that have assisted in reaching minority and rural populations:

   - The majority of the participants at the swap meets were Hispanic; therefore, this was an excellent method of reaching the Hispanic community.

   - AHCCCS has worked closely with the Arizona Interagency Farmworker Coalition (AIFC). Packets of information with eligibility criteria in English and Spanish were given and assistance with training was offered.

   - Arizona Rural Health Team has been another source of reaching the Hispanic and Farmworker communities. This team goes to the rural areas offering health screenings at schools and other sites. We participated in nine events producing 30 applications with 83 children.

   Through a grant from the Flinn Foundation, Arizona State University (ASU) is currently compiling the outreach program data for Children's Action Alliance, St. Luke's Charitable Trust, and the Flinn Foundation. The summary report is expected at the end of the three-year projects (2002). While it is too early for outcomes, these grants are allowing communities the opportunity to provide outreach that was previously unavailable. The research results will identify those strategies which were most successful and should be replicated.

   See also "Outreach" Section 1.1 #5, pages 2-7 for a description of numerous other successes.

3. Which methods best reached which populations? How have you measured effectiveness?

Personal contact with members at scheduled events has produced the best results. Radio advertising for an event and having radio personalities present at an event helps to reach the Hispanic population. The number of applications taken and number of children included on the applications is one way to measure the effectiveness of the events.

The effectiveness of the events can also be measured by the community contacts that are made. Other agencies, business people, community activists, and school nurses who become knowledgeable about the program and promote it in their communities or become actively involved in obtaining applications have to be considered when measuring effectiveness

Through a grant from the Flinn Foundation, Arizona State University (ASU) is currently compiling the outreach program data for Children's Action Alliance, St. Luke's Charitable Trust, and the Flinn Foundation. The summary report is expected at the end of the three-year projects (2002). The research results will also identify those strategies which were most successful and should be replicated.

SUBSECTION 2.5

RETENTION

1. What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

AHCCCS is using several strategies to accomplish this goal:

- A simple one-page renewal form for KidsCare members was recently developed and implemented. The form is in English and Spanish. The form is sent to the member with simplified instructions for completion. Both pages are blue to catch the eye of the member and to be easily identified in the KidsCare office. The form is too new for data to have been compiled but early responses indicate significant improvement over the previous, longer form.
- There is an exchange of information between Medicaid and KidsCare programs for renewals. Combined households Medicaid/KidsCare data is available in MIS system and Food Stamp records. This ensures that the member is not requested to provide the same verification for both Medicaid and KidsCare.
- When a child loses Medicaid due to excess income and is eligible for KidsCare, the child is systematically approved for KidsCare with no break in coverage. If there is a discrepancy that must be cleared prior to the child being approved for KidsCare, this information generates a report that is reviewed and processed by a KidsCare Eligibility Interviewer.
- A monthly report is received by the KidsCare program which lists all children who are presently eligible for Medicaid but whose eligibility will end in the coming months. This report is also reviewed and processed by KidsCare Eligibility Interviewers to ensure continuity of benefits.
- For the KidsCare program, members who are about to lose benefits because they are not current on premium payments, are contacted by KidsCare Eligibility Interviewers. The Interviewers remind the member about the premium and explain the procedures to follow in order to retain benefits.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

X Follow-up by caseworkers/outreach workers:
The community-based organizations that have assisted members with applications are starting to implement follow-up procedures. In the near future, these community-based organizations will receive a monthly list of members who have a renewal due the following month. They will contact the members and assist them in completing the renewal.

X Renewal reminder notices to all families:
A renewal reminder notice is sent to all members 20 days after the renewal form is sent. The family is contacted and sent an additional renewal notice before the member is discontinued.

X Targeted mailing to selected populations, specify population: AHCCCS is exploring the possibility of mailing out postcards on a quarterly basis. This will help to educate families such things as immunizations and well child visits. It can also assist as reminders to report such things as address changes.

X Information campaigns:
Public forums are conducted by the Public Information Officers to inform communities about all AHCCCS programs. The KidsCare and Medicaid programs are explained at these forums.

X Simplification of re-enrollment process, please describe:
A special procedure has been implemented for members who have been discontinued for nonpayment of premiums. If the back premiums are paid by the 25th of the month of discontinuance (e.g., member discontinued effective 1/1/01 and pays premiums 1/24/01), the member is re-enrolled effective 2/1/01 without requiring a reapplication.

N/A Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe

X Other, please explain:
When the post office returns mail as undeliverable, the KidsCare Eligibility Interviewer attempts to contact the member to locate a valid address from other programs such as Medicaid. If this is unsuccessful, the Eligibility Interviewer attempts to obtain a newer address from the member's Health Plan before discontinuing eligibility.

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.
During outreach events, information is provided concerning both programs.
Differences are as follows:

- There are no premiums for Medicaid; therefore there is no automatic re-enrollment.; and
- For the Medicaid population, any case discontinued due to income is screened to determine transitional Medical Assistance eligibility.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?
AHCCCS is continuously reviewing processes in order to use the best methods. Two of our endeavors are as follows:
   - The renewal application/process was revised three times.
     - Initially a computer-generated form was issued to the family for review and corrections. The form was difficult to read and the rate of return was low;
     - The second attempt to renew children was to send an original application form with the top boldly marked "Renewal Application". Again, the rate of return was low; and
     - The third attempt was to create a one-page renewal application form which was issued effective November 1, 2000. The return rate is encouraging but it is still too early to assess the results.
   - If the renewal application is not returned, the eligibility interviewer attempts to contact the family via telephone several times to get them to complete and return the form. They will also complete the application over the telephone and mail it to the primary representative for signature.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.
Arizona is participating in the SWAT Team sponsored by NASHP to collect disenrollment and reenrollment data.

SUBSECTION 2.6

COORDINATION BETWEEN SCHIP AND MEDICAID

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.
The KidsCare application is a joint SCHIP and Medicaid eligibility application. With this application, interviews may be conducted for either program. In addition, in some instances, the KidsCare renewal form is accepted by Medicaid as an application.

   There are some differences in verification requirements between KidsCare and Medicaid; however, in most cases, procedures have been implemented to prevent any impact on the member.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.
A unique partnership has been established between the KidsCare program and the Department of Economic Security (DES) who presently completes the Medicaid determinations for families and children. Medicaid workers are on-site at the KidsCare office. They assist with medical emergency cases which are usually approved the same day. Other potentially Medicaid eligible members are referred to the on-site DES Medicaid unit who screens them and transfers each case to the appropriate DES office for determination. If Medicaid is denied, the case is returned to KidsCare for an eligibility determination.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.
   The same health plans are available to Medicaid and KidsCare enrollees.

SUBSECTION 2.7

COST SHARING:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?
   In an informal poll taken by eligibility interviewers, members most commonly reported the following:
   - Forgot to pay the premium;
   - Didn't understand that the premium had to be paid even though they did not use the service that month; and
   - Had another expense which was more important for that month.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?
   No

SUBSECTION 2.8

ASSESSMENT AND MONITORING OF QUALITY OF CARE:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.
   AHCCCS measures the performance of its contracted health plans in delivering services to children, including those enrolled in KidsCare. A primary component of quality is access to care and utilization of services. As discussed elsewhere in this report, the agency monitors the adequacy of immunization of two-year-olds, tracking KidsCare members separately from children covered under Title XIX. Both eligibility groups are included in health plan performance measures that track rates of well-child visits for children up to 15 months of age and for those from 3 through 6 years old. In addition, the HCFA 416 Report, which tracks services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, will report KidsCare members separately for FY 1999/2000. That report is due to HCFA April 1, 2001.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

   For the monitoring of well child and baby care and immunizations, refer to 2.8 #1.

   Regarding behavioral health, AHCCCS requires the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to submit quarterly report findings and recommended improvements relative to the following Quality Management and Utilization

Management indicators for Title XXI members receiving mental health and substance abuse services:

- Referral to first service,
- Penetration rates,
- Cost of service provision,
- Symptomatic and Health Status Outcomes,
- Inpatient days per thousand,
- Average length of stay-inpatient, and
- Trends in grievance and request for hearing and problem resolution data.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?
See response to 2.8.1.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

SUBSECTION 3.1

PLEASE HIGHLIGHT SUCCESSES AND BARRIERS YOU ENCOUNTERED DURING FFY 2000 IN THE FOLLOWING AREAS. PLEASE REPORT THE APPROACHES USED TO OVERCOME BARRIERS. BE AS DETAILED AND SPECIFIC AS POSSIBLE.
Note: If there is nothing to highlight as a success or barrier, Please enter >NA= for not applicable.

1. Eligibility

There are three primary barriers:

- The first deals with the pubic charge issue. AHCCCS has worked extensively with community organizations to publicize that enrollment in KidsCare does not affect citizenship applications and that AHCCCS does not report information to the Immigration and Naturalization Service.
- The crowd-out provision, requiring six months ineligibility after the insurance is dropped, is another potential barrier.
- Income verification was a barrier. Effective October, 2000, AHCCCS changed the policy to accept income by declaration. We have a high percentage of part-time, seasonal and migrant workers who have difficulty obtaining income verification.

2. Outreach

Section 1.1.5 pages 2 -7, section 2.4 page 20 "Outreach" as well as section 2.5 #1-4 of this document demonstrate the outreach efforts and innovation that is currently and continuously occurring in Arizona.

Examples of successes other than those cited above are:

- Outstationing the Regional Outreach Coordinators to work in their local communities.
  - Of particular note, Regional Outreach Coordinators have worked closely with the Arizona Interagency Farmworker Coalition (AIFC) to enroll the farmworkers' children in KidsCare. AIFC has been provided with information packets in both English and Spanish for distribution. They also participated in the Celebration of Farmworker Day in Queen Creek and in Somerton collaborating with other community organizations to disseminate information and assist in completing applications.
- Building partnerships with the various community based organizations as well as participation in community.
- The Department of Education sent out a letter to all school programs asking them to attach a one-page flyer to the School Nutritional Program application. AHCCCS received over 7,000 applications from various schools throughout the state. Next year AHCCCS plan to obtain a more information on the application to assist us in making an eligibility determination without having to contact each family.

As the results of the foundation and tribal efforts are assessed, AHCCCS will continue to add to its data bank regarding successful outreach strategies.

3. Enrollment

Historically, enrollment has been an area that AHCCCS has excelled in due to our competitive bid process and the health plan selection we offer our members. This managed care format has enabled us to mainstream our members into health plans.

The Kaiser Commission on Medicaid and the Uninsured in the November, 2000 edition of "Enrollment Increases in State CHIP Programs: December, 1998 to December, 1999 indicates that Arizona is ranked fifth in the increase of growth for that timeframe with a percentage of growth of 648% (See Attachment F).

4. Retention/Disenrollment

N/A

5. Benefit Structure

The KidsCare program covered services are not the same as Medicaid. There are three differences: KidsCare has limits (30-day in-patient and 30 day outpatient) on behavioral health services and does not provide non-emergency transportation, and limits vision care to one eye exam and one pair of glasses per year.

6. Cost-Sharing

AHCCCS will continue to explore the use of credit cards or payroll deduction for premium payments.

7. Delivery Systems

N/A

8. Coordination with Other Programs

Highlights of AHCCCS efforts are as follows:

- Department of Economic Security Medicaid staff are co-located at the KidsCare office which provides for better communication, ease in processing emergency cases and overall Medicaid referrals.
- AHCCCS is in the process (effective December 1, 2000) of having a KidsCare brochure included in all envelopes mailed by Vital Statistics related to requests for birth certificates.
- Applications are available in the Vital Statistics lobby and they have posted eligibility information.
- AHCCCS has also been working with Arizona Department of Juvenile Corrections (ADJC) to submit applications on incarcerated juveniles during their release processing so that medical and behavioral health services are available the day they leave the juvenile facility.
- AHCCCS has been exploring the possibility of utilizing information obtained on the application for day care subsidy for KidsCare eligibility determination. Since their income threshold is 185% we believe most will quality for KidsCare.

9. Crowd-out
N/A

10. Other
None

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

SUBSECTION 4.1

Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care	$ 34,230,689	$ 40,050,715	$ 47,742,962
per member/per month rate X # of eligibles			
Fee for Service	1,062,354	1,498,241	1,962,853
Total Benefit Costs	35,293,043	41,548,956	49,705,815
(Offsetting beneficiary cost sharing payments)	(534,804)	(784,250)	(924,156)
Net Benefit Costs	34,758,239	40,764,706	48,781,659
Administration Costs			
Personnel	4,372,846	4,392,250	4,593,725
General administration			
Contractors/Brokers (e.g., Health Plans)	130,948	75,725	165,500
Claims Processing			
Outreach/marketing costs	420,860	1,000,000	
Other	1,188,575	1,815,075	2,914,925
Total Administration Costs	6,113,229	7,283,050	7,674,150
10% Administrative Cost Ceiling	3,862,025	4,529,412	5,420,184
Federal Share (multiplied by enhanced FMAP rate)	29,405,604	34,441,647	40,916,971
State Share	9,214,660	10,852,471	13,284,872
TOTAL PROGRAM COSTS	$ 38,620,264	$45,294,118	$54,201,843

SUBSECTION 4.2

PLEASE IDENTIFY THE TOTAL STATE EXPENDITURES FOR FAMILY COVERAGE DURING FEDERAL FISCAL YEAR 2000.
N/A

SUBSECTION 4.3

WHAT WERE THE NON-FEDERAL SOURCES OF FUNDS SPENT ON YOUR CHIP PROGRAM DURING FFY 2000?
_____ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
__X__ Other (specify) Allocation from the Tobacco Tax Fund

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

AHCCCS does not anticipate changes at this time.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

Subsection 5.1

TO PROVIDE A SUMMARY AT-A-GLANCE OF YOUR SCHIP PROGRAM CHARACTERISTICS, PLEASE PROVIDE THE FOLLOWING INFORMATION.
If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		KidsCare
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff __X__Other *(specify)* KidsCare Staff employed AHCCCS
Average length of stay on program	Specify months _____	Specify months NOT AVAILABLE AT THIS TIME
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __X__Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	_____No __X__Yes
Can apply for program over internet	_____No _____Yes	__X__No • However, the application is available on-line but must be printed out and completed. We do not have the capability of submission via Internet. _____Yes
Requires face-to-face interview during initial application	_____No _____Yes	__X__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months _____ What exemptions do you provide?	_____No __X__Yes, specify number of months __SIX__ What exemptions do you provide? • Each case is reviewed to establish whether there was an involuntary loss of insurance (e.g. due to death of the primary insurer or being laid off).
Provides period of continuous coverage <u>regardless of income changes</u>	_____No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____No __X__Yes, specify number of months _ Explain circumstances when a child would lose eligibility during the time period • Only after initial 12 months of eligibility.

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Imposes premiums or enrollment fees	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No __X__Yes, how much? • 0% to 150% of FPL have no premium. • Between 150% & 175% premium equals $10 per month for one child or $15 per month for 2 or more children • Between 175 % & 200% premium equals $15 per month for one child or $20 per month for 2 or more children. Who Can Pay? ___ Employer _X_ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	_____No _____Yes	__X__No _____Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__X__ No ___ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

SUBSECTION 5.2

PLEASE EXPLAIN HOW THE REDETERMINATION PROCESS DIFFERS FROM THE INITIAL APPLICATION PROCESS.
Both applications processes are the same. The differences are the verification of citizenship and the length of each application. The initial application is 4 pages while the renewal form is one page.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

SUBSECTION 6.1

AS OF SEPTEMBER 30, 2000, WHAT WAS THE INCOME STANDARD OR THRESHOLD, AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL, FOR COUNTABLE INCOME FOR EACH GROUP?
If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	_140% of FPL for children under age 1
	_133% of FPL for children aged 1 through 5
	_100% of FPL for children aged 6 plus (born after 10/1/83)
Medicaid SCHIP Expansion	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
State-Designed SCHIP Program	_200% of FPL for children aged 0 to 19____
	____% of FPL for children aged _____
	____% of FPL for children aged _____

SUBSECTION 6.2

AS OF SEPTEMBER 30, 2000, WHAT TYPES AND *AMOUNTS* OF DISREGARDS AND DEDUCTIONS DOES EACH PROGRAM USE TO ARRIVE AT TOTAL COUNTABLE INCOME?
Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable enter N/A.

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes X No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	**Medicaid SCHIP Expansion**	**State-designed SCHIP Program**
Earnings	$30 & Earned Income Student's Earned Income	N/A	$30 & Earned Income
Self-employment expenses	$0	N/A	$0
Alimony payments **Received**	$0	N/A	$0
Paid	$0	N/A	$0
Child support payments **Received**	$50	N/A	$50
Paid	$0	N/A	$0
Child care expenses	$200 maximum	N/A	$200 maximum
Medical care expenses	$0	N/A	$0
Gifts	$0	N/A	$0

Table 6.2			
	Title XIX Child Poverty-related Groups	**Medicaid SCHIP Expansion**	**State-designed SCHIP Program**
Other types of disregards/deductions (specify)	$90 Expense of Employment or Amount of Earned Income – Whichever is lower	N/A	$90 Expense of Employment or Amount of Earned Income – Whichever is lower

SUBSECTION 6.3

FOR EACH PROGRAM, DO YOU USE AN ASSET TEST?

Title XIX Poverty-related Groups __**X**__No ____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program __**N/A**__No ____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program __X__No ____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____ __**N/A**__No ____Yes, specify countable or allowable level of asset test_____

SUBSECTION 6.4

HAVE ANY OF THE ELIGIBILITY RULES CHANGED SINCE SEPTEMBER 30, 2000? ___ Yes _**X**__ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

SUBSECTION 7.1

WHAT CHANGES HAVE YOU MADE OR ARE PLANNING TO MAKE IN YOUR SCHIP PROGRAM DURING FFY 2001 (10/1/00 THROUGH 9/30/01)?
Please comment on why the changes are planned.

1. Family Coverage
   N/A

2. Employer Sponsored Insurance Buy-In
   N/A

3. 1115 Waiver
   N/C

4. Eligibility Including Presumptive And Continuous Eligibility
   N/A

5. Outreach
   AHCCCS recently hired a Community Relations Administrator that will work closely on KidsCare outreach projects. Some of her responsibilities include:
   - Serving as the agency focal point in reaching out to and resolving issues with community organizations,
   - Enhancing relationships with community based organizations to insure AHCCCS services are accessible to all citizens,
   - Functioning as the spokesperson for the Director in both informing and educating community organizations and in resolving issues with community organizations,
   - Managing grant funding for outreach and related activities, and
   - Seeking grants and other funds to develop agency needed programs in the outreach and educational area.

   In October, AHCCCS released a $1 million dollar request for proposal (RFP) to award grants to community based organizations to conduct outreach for Medicaid and uninsured children, specifically those qualifying under Section 1931 of the Social Security Act. Since approximately one-half of the children whose families have applied for KidsCare have been found Medicaid eligible, we expect that by conducting outreach for Medicaid we will find a large number of the children KidsCare eligible. The goal is to provide statewide coverage by awarding multiple contracts. AHCCCS hopes to award contracts by of January 2001.

   Another RFP has been released for $900,000 for a media campaign for KidsCare. The target date to award the contract for this RFP is January 2001.

The KidsCare program and the Arizona Association of Community Health Centers are planning a series of KidsCare outreach and enrollment seminars specifically designed for tribal health programs.

The Phoenix Children's Hospital (PCH) and Native American Community Health Center are working together to eliminate the cultural barriers that exist for urban Native American children. In addition to outreach efforts, PCH is offering free training to all KidsCare health plans. The training is designed to help develop an understanding of Native American cultural awareness and sensitivity.

The Social Security Administration (SSA) will be providing information regarding SCHIP to their beneficiaries. The information will include a toll free telephone number that will roll over to the KidsCare hotline. This effort will reach 664,900 Arizonans.

AHCCCS will also explore with the State Department of Revenue the potential of including information about KidsCare in their direct mailings.

The KidsCare Administration continues to partner with the community in outreach efforts. AHCCCS is researching best practices on an on going basis and receiving input from the community regarding more effective strategies in enrolling Arizona's children in health care.

6. Enrollment/Redetermination Process

AHCCCS has submitted a State plan amendment to HCFA for FFY2001. This amendment permits Arizona to accept the parental declaration of income for the KidsCare program. This expedites the enrollment process. The effective date is October, 2000.

AHCCCS will continue to explore simplifying the initial and renewal applications and the eligibility process.

7. Contracting

N/C

8. Other

None

Section 1

Description of Program Changes and Progress

Section 2

Areas of Special Interest

Section 3

Successes and Barriers

Section 4

Program Financing

Section 5

SCHIP Program at-a-Glance

Section 6

Income Eligibility

ATTACHMENTS

ATTACHMENT A, A-1 and A-2: OUTREACH MAPS
- Counties Targeted for Kids Outreach by AHCCCS Employees
- Counties Targeted for KidsCare Outreach by Foundations
- IHS Facilities and Other Entities that Target the KidsCare Population

ATTACHMENT B: APPLICATIONS
- Total Kids Approved for Health Care Coverage Due to KidsCare Graphic
- Number of Applications Graphic

ATTACHMENT C: KIDSCARE IMPACT
- KidsCare and Transfers To Title XIX Graphic

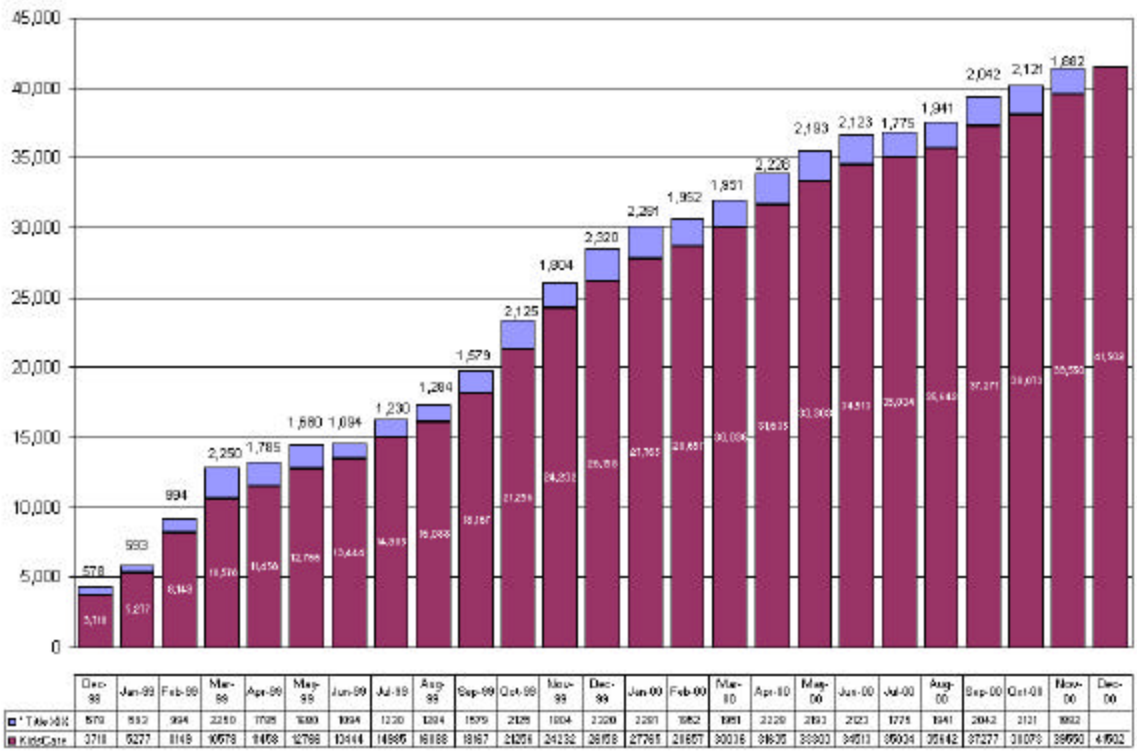
ATTACHMENT D: OUTREACH LIST
- List of Outreach Customers/Partners

ATTACHMENT E: KIDSCARE CONSUMER INFORMATION
- Flyer

ATTACHMENT F: STATE BY STATE SCHIP ENROLLMENT COMPARISON
- Kaiser Commission: Enrollment in State CHIP Programs: December 1998 to June 1999 (Chart)

ATTACHMENT G: CONTRIBUTING FACTORS TO MEDICAID GROWTH
- Additional information on increase in the Medicaid Population

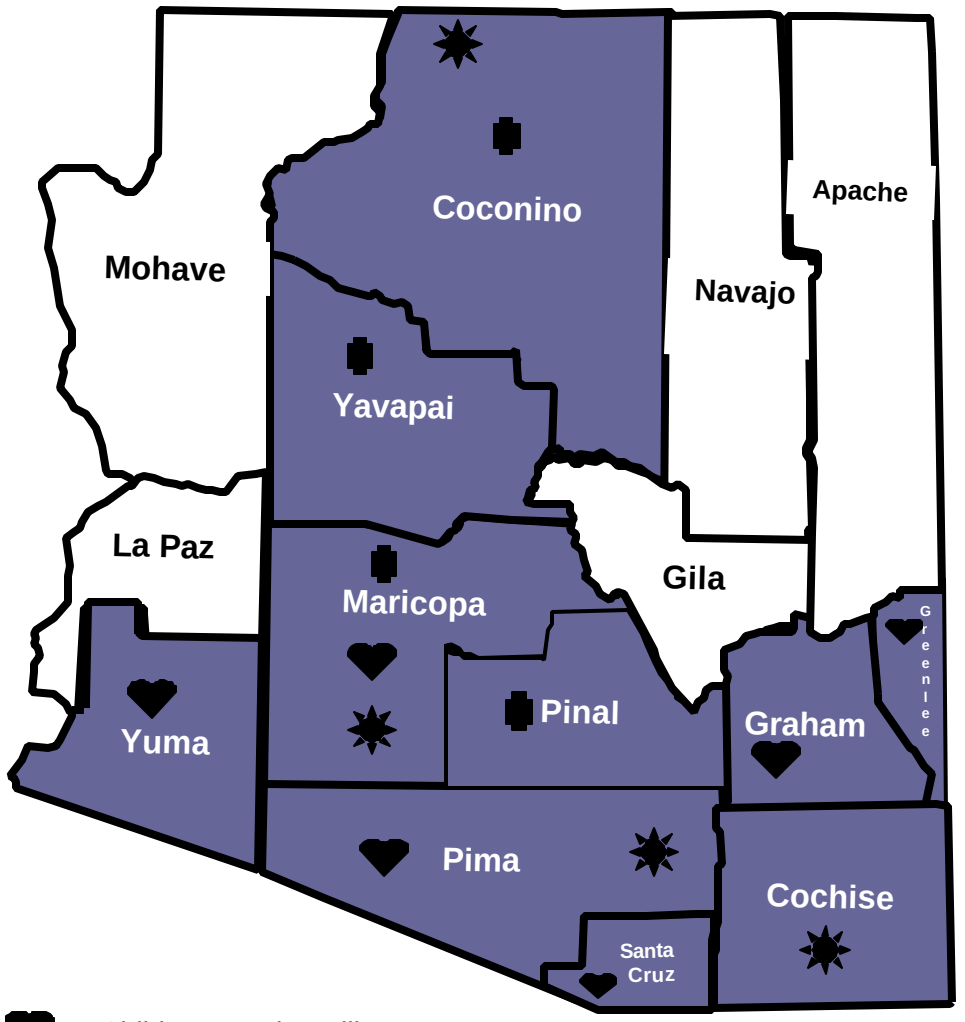
ATTACHMENT H: DEMOGRAPHICS
- Age
- Ethnicity


45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
578
993
994
2,250
1,785
1,680
1,094
1,230
1,284
1,579
2,125
1,804
2,220
2,291
1,952
1,851
2,226
2,193
2,123
1,775
1,941
2,042
2,121
1,882
Dec-98
Jan-99
Feb-99
Mar-99
Apr-99
May-99
Jun-99
Jul-99
Aug-99
Sep-99
Oct-99
Nov-99
Dec-99
Jan-00
Feb-00
Mar-00
Apr-00
May-00
Jun-00
Jul-00
Aug-00
Sep-00
Oct-00
Nov-00
Dec-00
Title XIX
KidsCare

ATTACHMENT A-1: OUTREACH MAP

KidsCare

Counties Targeted for KidsCare Outreach by Foundations



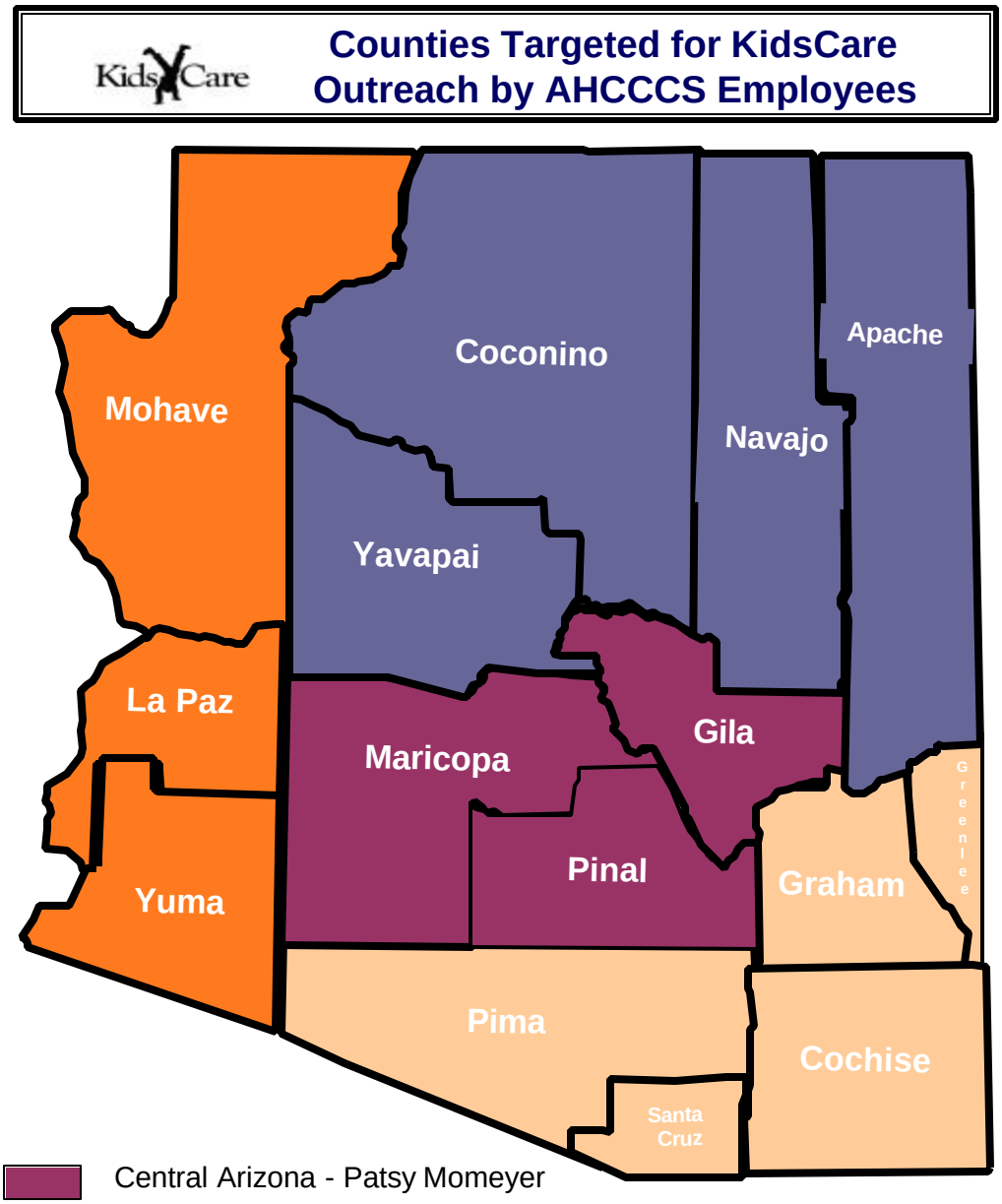
Children's Action Alliance

Flinn Foundation

St. Luke's Health Initiative

AHCCCS Outreach Coordinator:
Anna Alonzo - AMAlonzo@ahcccs.state.az.us
801 East Jefferson, MD 4100
Phoenix, Arizona 85034
Phone: (602) 417-4736 Fax: (602) 252-6536

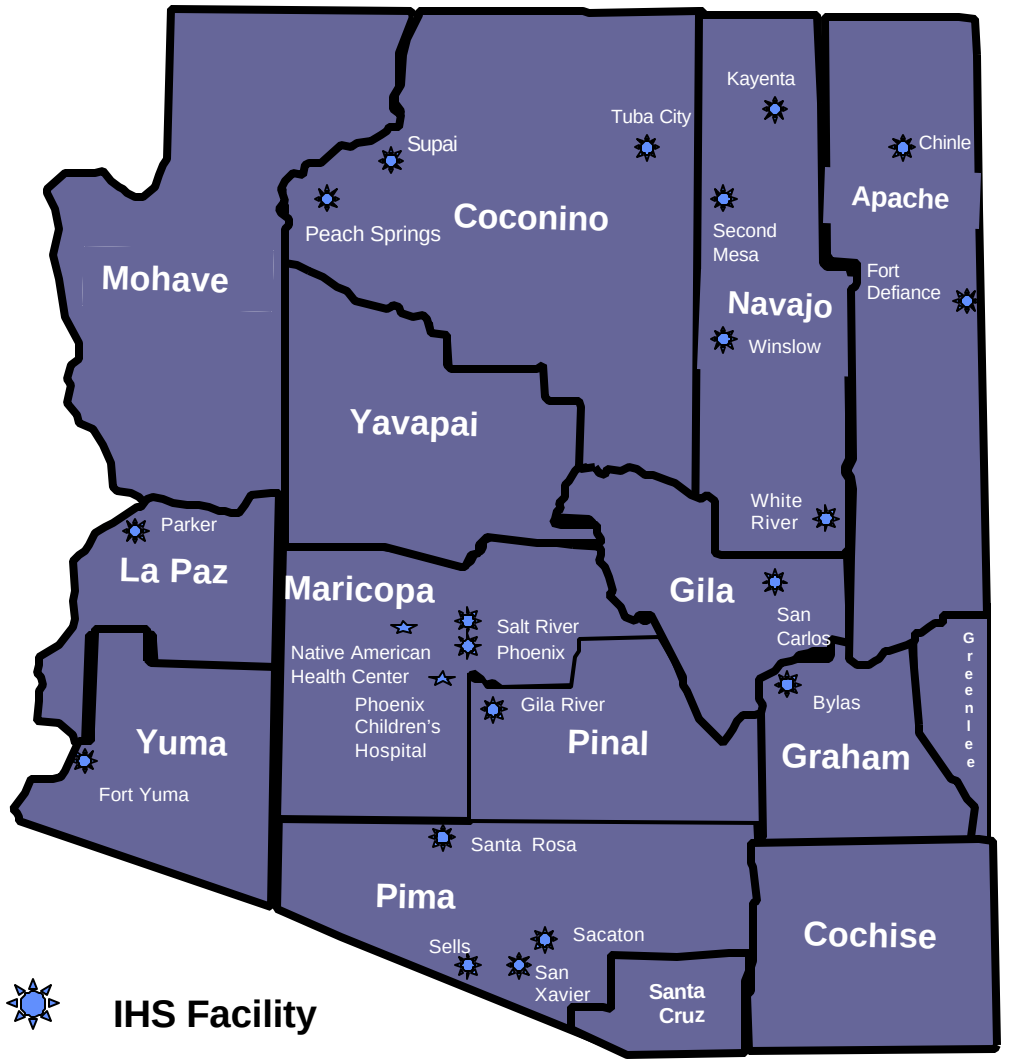
Attachment A: OUTREACH MAP



AHCCCS Outreach Coordinator:
Anna Alonzo - AMAlonzo@ahcccs.state.az.us
801 East Jefferson, MD 4100
Phoenix, Arizona 85034
Phone: (602) 417-4736 Fax: (602) 252-6536

ATTACHMENT A-2: OUTREACH MAP

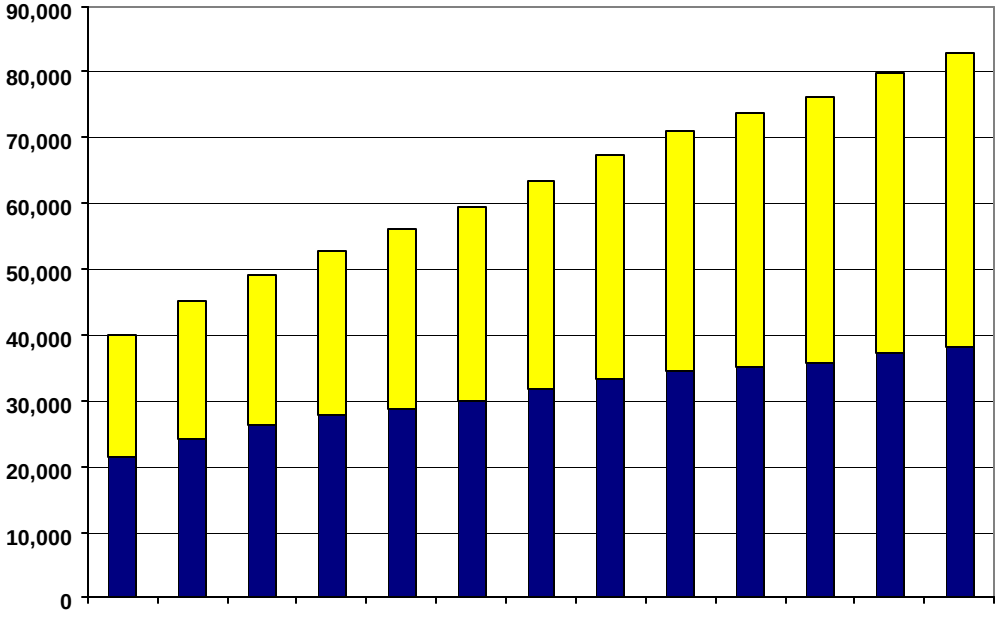
IHS FACILITIES and OTHER ENTITIES THAT TARGET KIDSCARE POPULATION



Native American Coordinator: Julia Ysaguirre
801 East Jefferson Street, MD 4200
Phoenix, Arizona 85034
Phone: (602) 417-4610 Fax: (602) 256-6756

ATTACHMENT B: APPLICATIONS

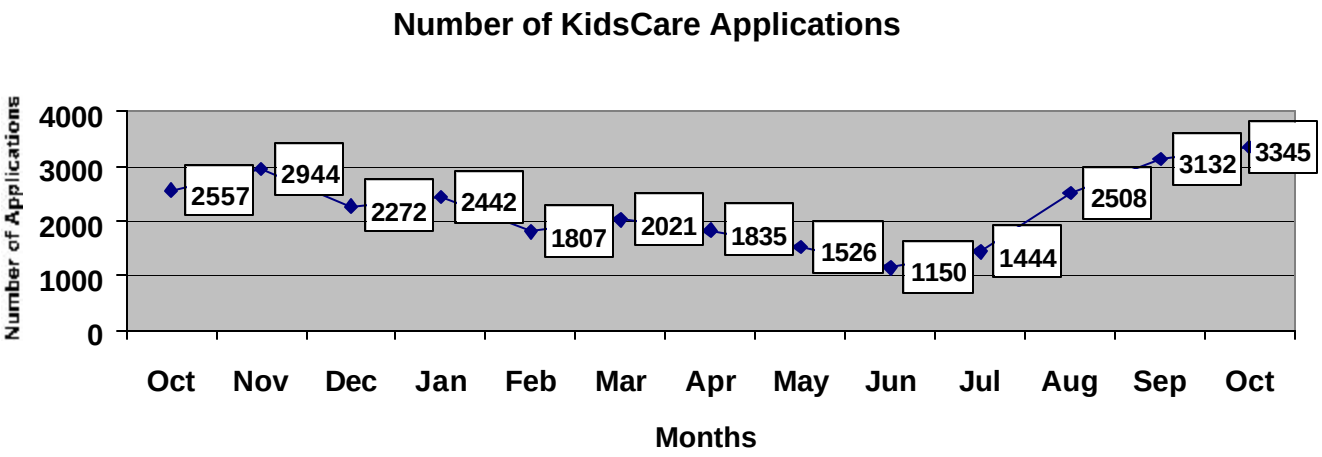
Total Kids Approved for Health Coverage due to KidsCare Applications



	Oct-99	Nov-99	Dec-99	Jan-00	Feb-00	Mar-00	Apr-00	May-00	Jun-00	Jul-00	Aug-00	Sep-00	Oct-00
Totals	39,949	45,236	49,106	52,675	56,020	59,515	63,296	67,341	70,907	73,715	76,215	79,966	82,979
Medicaid Enrollment due to KidsCare Applications	18,693	21,004	22,948	24,910	27,363	29,479	31,661	34,038	36,394	38,681	40,573	42,689	44,906
KidsCare Only	21,256	24,232	26,158	27,765	28,657	30,036	31,635	33,303	34,513	35,034	35,642	37,277	38,073

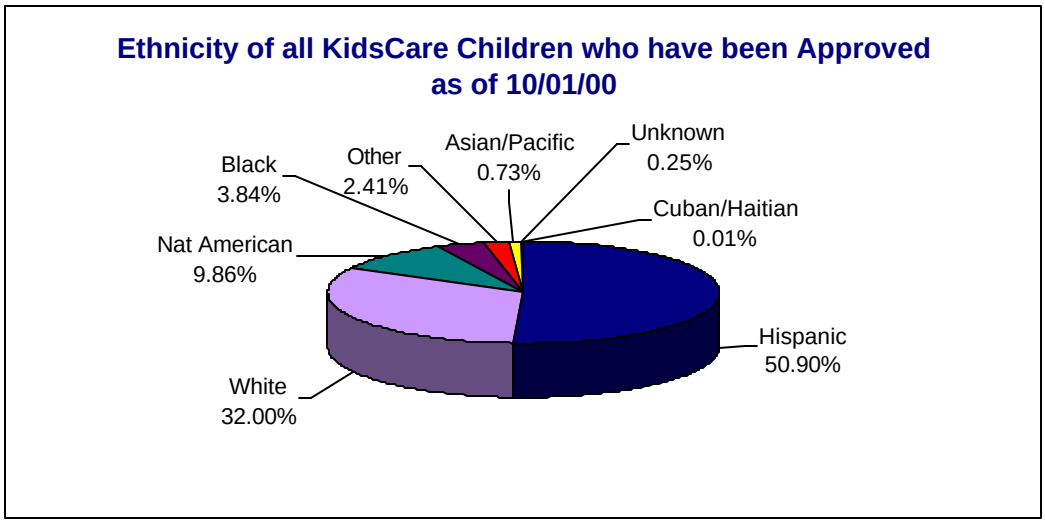
Source: The table is generated from monthly AHCCCS enrollment figures, which are in a point-in-time. Enrollment is for the 1st of each month.

This chart represents the 28,983 applications received from October 1999 to October 2000: however, these numbers do not include the conversions from the state programs or the Medicaid program through the Department of Economic Security when children become ineligible due to income or resources. During this same time period, the KidsCare hotline received 57,472 calls.

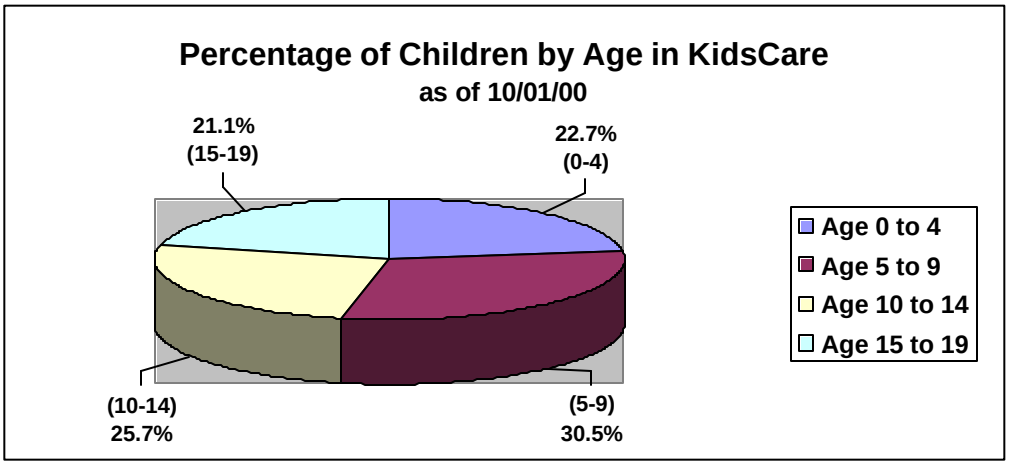


ATTACHMENT H: DEMOGRAPHICS

ETHNICITY



AGE



ATTACHMENT D

SOME OF OUR OUTREACH CUSTOMERSIPARTNERS

Adult Parole
Alhambra Little League
Americor
Arizona Diamondbacks
Arizona Rural Health Fair
Arizona School Food Service Association
Balse Pride Day - Gateway College
Benefit Coordinators of Arizona
Cali Ollin Academy
Carondelet Foundation and Community Trust
Carondelet Foundation Promotoras
Catalina HS Community Coalition
Catalina HS Wellness Center
Catholic Social Services
Centers for Habilitation
Chandler Christian Church
Chandler Fire Department
Chicanos Por La Causa
Children Center Pre-School
Children's Action Alliance
Cigna
City of Phoenix Fight Back Program
City of Phoenix Neighborhood Services
City of Yuma
City of Yuma Department of Community Development
Cocopah Headstart
Cocopah Indian Tribe
Department of Economic Security
Department of Economic Security Child Care Administration
Department of Economic Security District Managers Meeting
Dr. Chiavacci Pediatric Office
Drexel Heights Fire Department
Eggees Corporation
El Rio Clinic
Erickson Elementary Headstart Center
Excel Behavioral Health
Federal Credit Union
Federal Probation Office
Fiesta Mail
First Southern Church
Fred G. Acosta Job Corp
Fun and Fitness
Gilbert Health Center
Girl Scout Parents Meeting
Governor's Employee Celebration
Granada Health Fair
Grandparents Raising Grandchildren

SOME OF OUR OUTREACH CUSTOMERSIPARTNERS

San Luis Headstart Program
San Luis School Base Health Clinic
Santa Rosa Neighborhood Coalition
School Health Service
Senora Behavioral Health
Sign-A-Rama
SOS Temporary Service
Southwest Behavioral Health
St. John Vianney Catholic Church
St. Joseph's Hospital Intake Unit
St. Marks Church
St. Mary's Intake
State of Arizona Superior Court Judges
Super Kmart
Swap Meet
Title I Family Support Conference
Tomahawk Village Block Watch
Tribe and Lazona HIV/AIDS Awareness Fair
Tucson Convention Center
Tucson Care Fair Planning Committee
Tucson Citizen Newspaper
Tucson Medical Center
Tucson Scorch HockeyTeam
Tucson Unified School District Nurses
Tucson Volunteer Center
University of Arizona College of Medicine
Victim Services
Volunteer Center of Tucson
WACOG Orange Grove Headstart
WACOG Rancho Viejo Headstart
WACOG West Yuma Headstart
WAGOG Foothills Headstart
WAHEC
Whiz Kids Day Care Center
Women's Health Clinic
WROHSE Conference 2000 - The Yuman Connection
Youth With Special Needs Transition Fair
Yuma County Health Department
Yuma Daily Sun
Yuma Nursing
Yuma Pre-School Day Care Center
Zion Rest District Nurses Association

ATTACHMENT G

CONTRIBUTING FACTORS TO MEDICAID GROWTH

Introduction:
There has been a growth of approximately 14 percent in the total AHCCCS population within the past year. The largest growth in the population involves the programs for which DES determines eligibility. The members qualifying under these programs increased by 49,464 from 295,805 in 10/01/99 to 345,269 as of 10/01/00. This is an increase of 16.7%.

- **The two programs experiencing the most growth in the past twelve months (10/99–10/00) are:**

- Families with children qualifying under Section 1931 of the Social Security Act increased:

Program	10/1/99	10/1/00	Increase	%
1931	78,498	122,210	43,712	55.7%

- Some of the growth in the Section 1931 group is a result of members shifting from one group to another (Example: A category referred to as AF related decreased):

Program	10/1/99	10/1/00	Decrease	%
AF Related	19,887	11,328	8,559	43.0%
SOBRA PW	13,021	11,604	1,417	10.8%

- Transitional Medical Assistance program also increased dramatically:

Program	10/1/99	10/1/00	Increase	%
TMA	17,783	32,302	14,519	81.6%

- **Factors contributing to this growth in the DES determined programs:**

- Redeterminations scheduled less frequently so fewer members discontinued for failure to keep redetermination interviews.

- Redetermination for members receiving Medical Assistance Only (MAO) was changed from every 6 months to annually.

- DES has reduced the number of household receiving combined Food Stamps and Medical Assistance who have to be recertified/redetermined eligible for benefits quarterly.

- Eliminated barriers to completing redetermination

- Families with children receiving MAO coverage who applied through the KidsCare Program may complete the redetermination by phone or mail in lieu of an office visit.

- Office visits (face to face) for redeterminations have been waived for some additional members.

- DES has extended office hours before 8:00 am and after 5:00pm and in some offices and are open on Saturday in some offices to accommodate working families.

- AHCCCS funded from enhanced federal funding additional staff at DES to review the cases of families whose

benefits were being terminated to ensure the action was correct or if the family could continue to qualify under TMA the AHCCCS coverage was reinstated.

- DES increased attempts to contact families who did not keep office appointment or who had changed their address rather than terminating benefits immediately.

All of the above actions were taken to make the AHCCCS coverage more accessible to families and children.

The KidsCare Outreach and simplified application/eligibility process has resulted in approximately 2000 children per month being transferred to or found eligible for Medicaid.

Table 1

Total CHIP Enrollment, December 1998 to December 1999

	Program Type,	Enrollment Dec-98	**Jun-99**	Dec-99	Percent Change 12/98-6/99	6/99-12/99	**12/98-12/99**	
United States		833,303	1,298,542	**1,766,174**	560/6	360/6	112%	
Alabama	C	22,102	31,258	33,337	41%	7%	51%	
Alaska	M	0	3,093	7,346	NA	138%	NA	
Arizona	S	3,710	14,985	27,765	304%	85%	648%	
Arkansas	M	341	712	1,021	109%	43%	199%	
California	C	55,189	133,991	202,514	143%	51%	267%	
Colorado	S	11,704	17,783	23,375	5 29/6	31%	100%	
Connecticut	C	5,524	8,569	9,088	55%	6%	65%	
Delaware	S	0	1,732	2,494	NA	44%	NA	
District of Columbia	M	569	1,924	2,187	238%	14%	284%	
Florida	C	56,265	101,080	124,763	80%	23%	122%	
Georgia	S	0	31,085	56,116	NA	81%		NA
Hawaii	M	0	0	0	NA	NA	NA	
Idaho	M	2,937	3,541	4,728	21%	34%	61%	
Illinois	M	26,877	38,586	47,020	44%	22%	75%	
Indiana	M	24,982	28,909	31,668	16%	10%	27%	
Iowa	M	7,004	9,252	9,979	32%	8%	420%	
Kansas	S	0	11,024	15,206	NA	36%	NA	
Kentucky	C	1,145	8,179	31,783	614%	289%	2676%	
Louisiana	M	3,741	17,628	26,581	371%	51%	611%	
Maine	C	4,490	6,514	8,147	45%	25%	81%	
Maryland	M	9,192	14,494	16,160	58%	11%	76%	
Massachusetts	C	28,146	31,565	52,508	12%	66%	87%	
Michigan	C	10,949	17,738	20,467	62%	15%	87%	
Minnesota	M	8	8	4	0%	-50%	-50%	
Mississippi	C	5,968	7,717	11,380	29%	47%	91%	
Missouri	M	24,910	42,251	54,306	70%	29%	118%	
Montana	S	0	943	2,458	NA	161%	NA	
Nebraska	M	3,764	5,192	6,252	38%	20%	66%	
Nevada	S	2,782	6,545	7,634	135%	17%	174%	
New Hampshire	G	11	1,568	2,169	NA	38%	NA	
New Jersey	C	22,926	35,574	52,322	55%	47%	128%	
New Mexico	M	0	868	2,383	NA	175%	NA	
New York	S	270,683	352,273	425,522	30%	21%	57%	
North Carolina	S	17,887	43,774	55,723	145%	27%	212%	
North Dakota	M	79	92	1,026	16%	1015%	1199%	
Ohio	M	35,300	38,420	64,609	9%	68%	83%	
Oldahoma	M	15,523	25,452	32,503	64%	28%	109%	
Oregon	S	10,366	12,608	14,118	22%	12%	36%	
Pennsylvania	S	68,376	78,998	87,592	16%	11%	28%	
Rhode Island	M	2,981	4,666	6,978	57%	50%	134%	
South Carolina	M	34,026	42,198	43,773	24%	4%	29%	
South Dakota	M	1,405	2,038	2,789	45%	37%	99%	
Tennessee	M	0	0	16,935	NA	NA	NA	
Texas	M	34,826	34,527	28,490	-1%	*-17%*	18%	
Utah	S	4,438	9,937	13,709	124%	380/6	209%	
Vermont	S	406	1,095	1,632	170%	49%	302%	
Virginia	S	1,420	12,138	19,569	755%	61%	1278%	
Washington	S	0	0	0	NA	NA	NA	
West Virginia	C	351	2,618	6,935	646%	241%	2446%	
Wisconsin	M	0	3,400	49,110	NA	1344%	NA	
Wyoming	S	0	0	0	NA	NA	NA	

*M = Medicaid Expansion (23) S Separate Program (16) /C = Combined Program (12)

Note: As of 12131199 CHIP was implemented in 47 States and the District of Columbia, CHIP

was not implemented in Hawaii, Washington, and Wyoming, Increases above 10,000% reported as NA.

KidsCare
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Committed to Excellence in Health Care

Jane Dee Hull
Governor

Phyllis Biedess
Director

Table 1: State CHIP Enrollment as Reported by State Officials, December 1998 and June 1999

State	Number of Enrolled Children, Dec-98**	Number of Enrolled Children, Jun-99	Change in Enrollment	Percent Chnange
Alabama	22,102	32,626	10,524	48%
Alaska*	—	3,093	3,093	N/A
Arizona	3,710	14,985	11,275	304%
Arkansas*	341	712	371	109%
California	55,189	133,991	78,802	143%
Colorado	11,704	17,783	6,079	52%
Connecticut	7,460	10,150	2,690	36%
Delaware*	—	2,800	2,800	N/A
District of Columbia	569	1,924	1,355	238%
Florida	56,265	101,080	44,815	80%
Georgia	^	31,085	31,085	N/A
Hawaii*	—	—	—	N/A
Idaho	2,937	3,541	604	21%
Illinois	26,877	38,586	11,709	44%
Indiana*	24,982	28,909	3,927	16%
Iowa	7,004	9,252	2,248	32%
Kansas	—	11,024	11,024	N/A
Kentucky*	1,145	9,000	7,855	686%
Louisiana	3,741	17,628	13,887	371%
Maine	4,729	6,404	1,675	35%
Maryland	9,192	14,494	5,302	58%
Massachusetts	30,912	46,867	15,955	52%
Michigan	10,204	17,256	7,052	69%
Minnesota*	8	8	0	0%
Mississippi	5,968	7,717	1,749	29%
Missouri	24,910	42,251	17,341	70%
Montana	—	943	943	N/A
Nebraska	3,764	5,192	1,428	38%
Nevada	2,782	6,545	3,763	135%
New Hampshire	—	1,426	1,426	N/A
New Jersey	20,153	33,548	13,395	66%
New York	270,683	352,273	81,590	30%
North Dakota*	79	92	13	16%
Oklahoma*	18,000	25,000	7,000	39%
Oregon	10,366	12,608	2,242	22%
Pennsylvania	68,376	78,998	10,622	16%
South Carolina	34,026	42,198	8,172	24%
Tennessee*	—	—	—	N/A
Texas*	34,826	34,533	-293	-1%
Utah	2,036	4,656	2,620	129%
Vermont	406	1,095	689	170%
Virginia	1,420	12,138	10,718	755%
Washington*	—	—	—	N/A
West Virginia	351	3,382	3,031	864%
Wyoming*	—	—	—	N/A

-: State did not have program in operation.

^ Georgia implemented a pilot program with 600 children as of December 1998.
* See notes on next page.
Source: Health Management Associates, Survey of State Officials, July 1999.

Dear KidsCare Family:

- **It is time for your KidsCare health insurance annual renewal. Your annual renewal form is enclosed.**
- **To maintain your KidsCare health insurance, complete the enclosed form and return within <u>five</u> days from the day you receive this notice.**
- If you have questions or need help filling out this form call 602-417-5437 (Phoenix) or toll free 1-877-764-5437 (Statewide)
- **If we do not receive this completed form with required verification listed below, we cannot renew your children's insurance.**

<u>REQUIRED VERIFICATION</u>

Vea el reverso para Español

1. Income

- All Pay stubs received in the prior thirty days for all employed children, parents, and stepparents.

Or

- A statement from the employer indicating gross wages received in the prior thirty days.
- If a child, parent, or stepparent is self-employed, please provide copies of current Federal Tax forms: 1040, Schedule SE and C. Provide a statement that tells us if you expect a change in your self-employment income or if you do not expect a change in your self-employment income.

Or

- If your tax forms are unavailable of if you expect a change in income from last year, provide verification of last months total business income. This verification can be records, ledgers, or written statement. If you have business related expenses, copies of all receipts must be provided to allow deductions.
- Child Support payment history form or court order.
- Verification of Social Security, veteran's benefits, pension, disability payments, dividends and interest received in the prior month.
- For all other income provide a written statement which verifies amount and how often the income is received.

2. Citizenship

If you want to add any child to your KidsCare health insurance coverage, attach proof of citizenship or immigration status if that child was born outside United States.

3. Private Health Insurance Coverage

If any child covered by KidsCare Health Insurance or any child for whom you are applying has private insurance coverage attach a copy of insurance ID cards or a separate sheet of paper that lists the insurance company name, policy number and the names of the children covered by that insurance.

4. Dependent Care Expense

Attach proof of amount paid for day care or for the care of an elderly or disabled adult so someone in your home can work.

Estimada familia de KidsCare:

- **Ya es hora de la renovación anual del seguro médico de KidsCare. Adjunto se encuentra el formulario de la renovación anual.**
- **Para mantener vigente el seguro médico de Kidscare, llene el formulario adjunto y devuévalo en el plazo de cinco días después de recibir este aviso.**
- Si usted tiene alguna pregunta o si necesita ayuda para llenar este formulario, llame al 602-417-5437 (Phoenix) o gratis al 1-877-764-5437 (en todo el estado)
- **Si no recibimos este formulario rellenado junto con las constancias necesarias indicadas abajo, no podremos renovar el seguro de sus hijos.**

CONSTANCIAS NECESARIAS

See reverse side for English

5. Ingresos

- Todos los talones de cheque de pago recibidos durante los 30 días anteriores de todos los hijos, padres y padrastros empleados.

Ó

- Una declaración de parte del empleador indicando los ingresos brutos recibidos durante los 30 días anteriores.
- Si el hijo, padre o padrastro trabaja por cuenta propia, favor de proporcionar copias de los formularios federales de impuestos del año: 1040, Schedule SE y C. Dénos una declaración diciendo si usted espera algún cambio de sus ingresos de trabajo por cuenta propia o si no espera ningún cambio de estos.

Ó

- Si usted no tiene sus formularios de impuestos o si espera algún cambio de ingresos en comparación al año pasado, proporcione constancia del total de los ingresos de negocio del último mes. Esta constancia puede ser registros, libros de contabilidad o una declaración por escrito. Si usted tiene gastos relacionados con el negocio, debe proporcionar copias de todos los recibos para poder permitir las deducciones.
- Formulario del historial de pagos u orden judicial de la manutención infantil.
- Constancia del Seguro Social, prestaciones de veterano, pensión, pagos por incapacidad, dividendos e intereses recibidos el mes anterior.
- Por los demás tipos de ingresos, proporcione una declaración por escrito que conste la cantidad y con qué frecuencia se reciben.

6. Ciudadanía

Si usted desea agregar a algún hijo al seguro médico de KidsCare, adjunte constancia de su ciudadanía o estado migratorio si el hijo nació fuera de los Estados Unidos.

7. Cobertura Médica Particular

Si algún hijo cubierto por el seguro médico de KidsCare tiene seguro médico particular, o lo tiene algún hijo para el cual usted está solicitando el KidsCare, entonces adjunte una copia de la tarjeta de identificación del seguro o una hoja por separado indicando el nombre de la compañía de seguros, el número de la póliza y los nombres de los hijos cubiertos por el seguro.

8. GASTOS DE CUIDADO DE LOS DEPENDIENTES

Adjunte constancia de la cantidad pagada por el cuidado infantil o por el cuidado del adulto anciano o incapacitado, lo cual permite que alguien de su hogar pueda trabajar.